CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445099	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, ATHENS	1204 FRYE ST ATHENS, TN 37303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 1 failed to maintain the sprinkler system. NFPA 101, 2012 Edition 19.3.5.1, 9.7.1.1 NFPA 13, 2010 Edition 7.2.5.2.2 The deficiency affected residents in 6 of 6 smoke compartments. Findings include: Based on observation and interview with the maintenance director, on 11/28/16 at 12:45 PM revealed the sprinkler riser room failed to have a permanently installed heat source. The maintenance director was present when the deficiency was identified and acknowledged by the administrator during the exit conference on 11/28/16.	K 351	(This page is blank)	